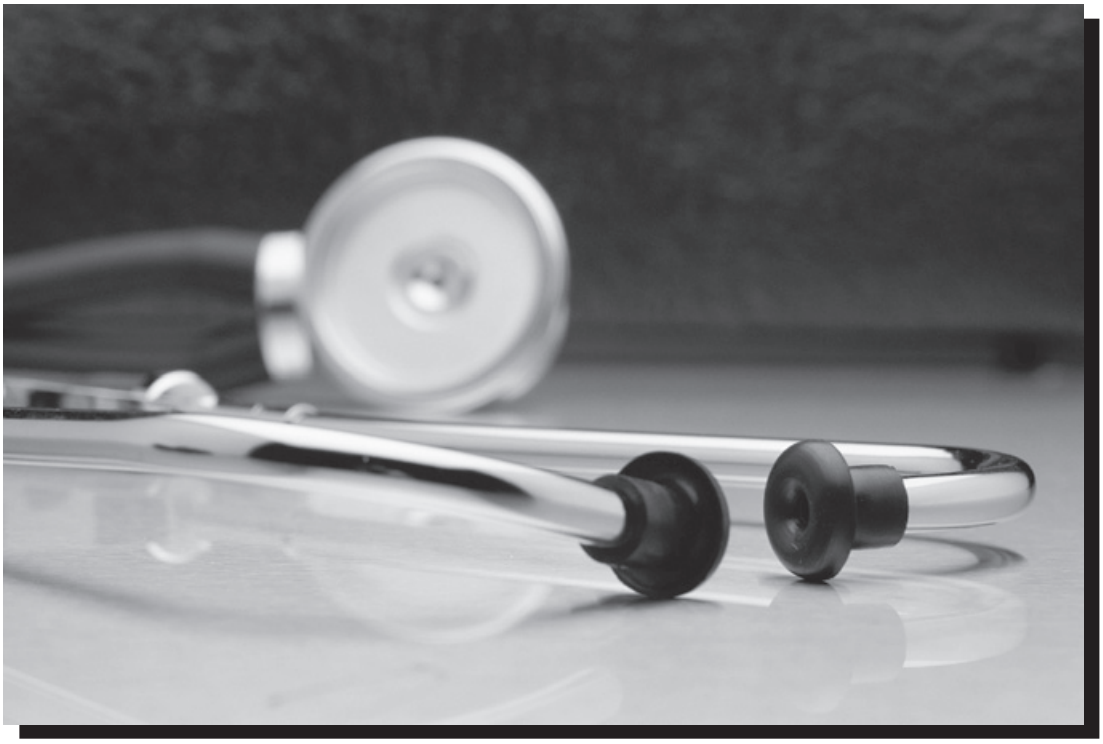
Leading Health Care
In The 21st Century



New York State Health Care Proxy and Living Will

QUALITY CARE LEADING PARTNERING

VA HEALTHCARE NETWORK
UPSTATE NEW YORK

QUALITY CARE LEADING PARTNERING

Information About the New York State Health Care Proxy Document

This is an important legal form. Before signing this form, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, except to the extent you say otherwise in this form. "Health Care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless you state otherwise, your agent will be allowed to make all health care decisions for you, including decisions to remove or withhold life-sustaining treatment.
3. Unless your agent knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube), he or she will not be allowed to refuse or consent to those measures for you.
4. Your agent will start making decisions for you when doctors decide that you are not able to make health care decisions for yourself.

   You may write on this form any information about treatment that you do not desire and/or those treatments that you want to make sure you receive. Your agent must follow your instructions (oral and written) when making decisions for you.

   If you want to give your agent written instructions, do so right on the form. For example, you could say:

   *"If I become terminally ill, I **do/don't** want to receive the following treatments..."*
   *"If I am in a coma or unconscious, with no hope of recovery, then I **do/don't** want..."*
   *"If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I **do/don't** want..."*
   "I have discussed with my agent my wishes about _____ and I want my agent to make all decisions about these measures."

   Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list of the treatments about which you may have instructions.

   - artificial respiration
   - artificial nutrition and hydration (nourishment and water provided by feeding tube)
   - cardiopulmonary resuscitation (CPR)
   - antipsychotic medication
   - electric shock therapy
   - antibiotics
   - psychosurgery
   - dialysis
   - transplantation
   - blood transfusion
   - abortion
   - sterilization

Talk about choosing an agent with your family and/or close friends. You should discuss this form with a doctor or another health care professional, such as a nurse or social worker, before you sign it to make sure that you understand the types of decisions that may be made for you. You may also wish to give your doctor a signed copy. **You do not need a lawyer to fill out this form.**

You can choose any adult (over 18), including a family member, or close friend, to be your agent. If you select a doctor as your agent, he or she may have to choose between acting as your agent or as your attending doctor. A physician cannot do both at the same time. Also, if you are a patient or a resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. You should ask the staff at the facility to explain those restrictions.

You should tell the person you choose that he or she will be your health care agent. You should discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.

Even after you have signed this form, you still have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object. You can cancel the control given to your agent by telling him or here or your health care provider orally or in writing.

FILLING OUT THE PROXY FORM

Item (1): Write your name and the name, home address and telephone number of the person you are selecting as your agent.

Item (2): If you have special instructions for your agent, you should write them here. Also, if you wish to limit your agent's authority in any way, you should say so here. If you do not state any limitations, you agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

Item (3): You may also write the name, home address and telephone number of an alternate agent.

Item (4): This form will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want the health care proxy to expire.

Item (5): New York State law allows you to give instructions concerning organ and tissue donation in this section. **You do not have to fill out this section of the Health Care Proxy for the document to be valid.**

Item (6): You must date and sign the proxy. If you are unable to sign it yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (7): Two witnesses at least 18 years of age must sign your proxy. The person who is appointed agent or alternate agent cannot sign as a witness.

New York State Health Care Proxy

(1) I, _____
(PRINT YOUR FIRST, MIDDLE AND LAST NAME)

hereby appoint _____
(PRINT YOUR PROXY'S FIRST, MIDDLE AND LAST NAME)

of _____
(PRINT YOUR PROXY'S HOME ADDRESS AND TELEPHONE NUMBER)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect in the event I become permanently unable to make my own health care decisions.

(2) **Optional instructions:** I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. (Attach additional pages if necessary.)

_____

_____

_____

_____

(Unless your agent knows your wishes about artificial nutrition and hydration [feeding tubes], your agent will not be allowed to make decisions about artificial nutrition and hydration. See instructions contained herein for samples of language you could use.)

(3) Name of substitute or alternate agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

_____
(PRINT YOUR SUBSTITUTE PROXY'S FIRST, MIDDLE AND LAST NAME)

_____
(PRINT YOUR SUBSTITUTE PROXY'S HOME ADDRESS AND TELEPHONE NUMBER)

(4) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated below. This proxy shall expire (specify date or conditions, if desired):

_____

_____

_____

_____

(5) **Anatomical Gift Donation** *(optional)*. Initial one of the following statements.

_____ I do **not** wish to make any anatomical gift.

_____ I hereby make this anatomical gift, if medically acceptable, to take effect upon my death.

I give: *(check one)*

_____ (1) any needed organs, tissues or parts.

_____ (2) only the following organs, tissues or parts:

_____

_____

to be donated for: *(check one)*

_____ (1) any purpose allowed by New York State Law.

_____ (2) these limited purposes:

_____

_____

PRINCIPAL SIGNATURE

(6) Signature: _____ Date: _____

Address: _____

_____

Date of Birth: _____ Social Security Number: _____

WITNESS SIGNATURES

(7) I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence. I further declare that I am at least 18 years of age, and am not the agent or alternate agent appointed in this document.

Name of Witness (PRINT): _____

Signature: _____

Address: _____

Name of Witness: (PRINT): _____

Signature: _____

Address: _____

NEW YORK STATE LIVING WILL

I, _____ , being of sound mind, make
(Print Name)

this statement as a directive to be followed in the event I become permanently unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below:

I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying, if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery.

These instructions apply if I am: a) in a terminal condition; b) permanently unconscious; or c) if I am minimally conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment.

While I understand that I am not legally required to be specific about future treatments if I am in the condition(s) described above I feel especially strong about the following forms of treatment: (Initial your choices on the lines provided.)

_____ I do not want cardiac resuscitation.
_____ I do not want mechanical respiration.
_____ I do not want tube feeding.
_____ I do not want antibiotics.
_____ I do want maximum pain relief.

Other directions (insert personal instructions): _____

_____

_____

DECLARANT SIGNATURE

These directions express my legal right to refuse treatment under the laws of New York State. I intend my instructions to be carried out, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

Signed: _____ Date: _____

Address: _____

_____

Date of Birth: _____ Social Security Number: _____

WITNESS SIGNATURES

Witness: _____

Address: _____

Witness: _____

Address: _____

Reaching Us Is Easy

VA Medical Centers:

Albany
113 Holland Avenue
Albany, NY 12208
(518) 626-5000

Batavia
222 Richmond Avenue
Batavia, NY 14020
(585) 343-7500

Bath
76 Veterans Avenue
Bath, NY 14810
(607) 664-4000

Buffalo
3495 Bailey Avenue
Buffalo, NY 14215
(716) 834-9200

Canandaigua
400 Fort Hill Avenue
Canandaigua, NY 14424
(585) 394-2000

Syracuse
800 Irving Avenue
Syracuse, NY 13210
(315) 425-4400

Community-Based Outpatient Clinics:

Auburn
Auburn Memorial Hospital
17 Lansing St.
Auburn, NY 13021
(315) 255-7002

Bainbridge
109 North Main Street
Bainbridge, NY 13733
(607) 967-8590

Binghamton
425 Robinson Street
Binghamton, NY 13001
(607) 772-9100

Catskill
Greene Medical Bldg.
159 Jefferson Heights
Catskill, NY 12414
(518) 943-7515

Clifton Park
1673 Route 9
Clifton Park, NY 12065
(518) 383-8506

Cortland
1104 Commons Avenue
Cortland, NY 13045
(607) 662-1517

Dunkirk
The Resource Center
325 Central Avenue
Dunkirk, NY 14048
(716) 366-2122

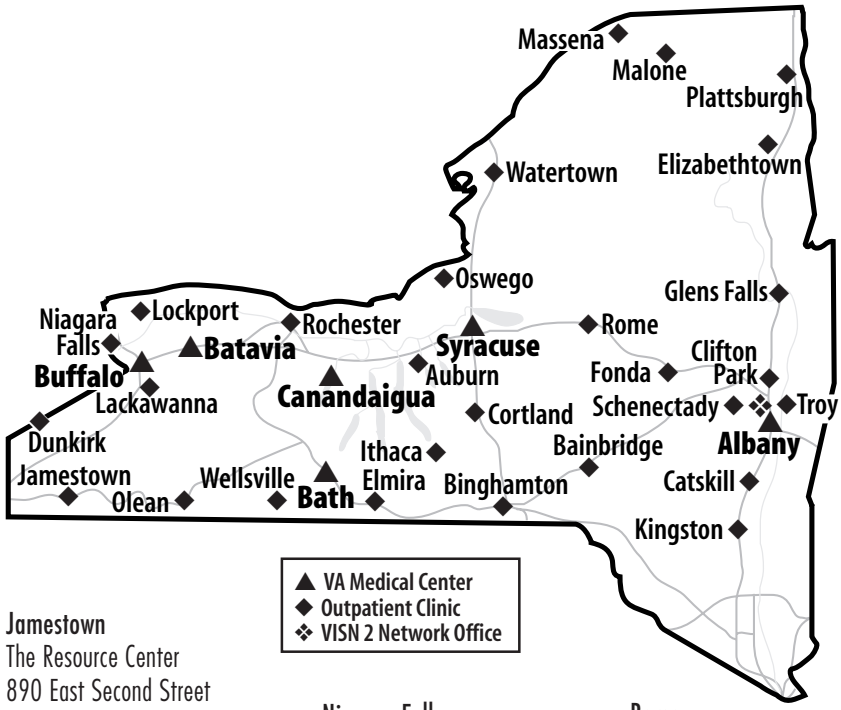
Elizabethtown
P.O. Box 277, Park St.
Elizabethtown, NY 12932
(518) 873-3295

Elmira
Health Services Bldg.
200 Madison Ave.
Suite 2E
Elmira, NY 14901
(877) 845-3247

Fonda
Camp Mohawk Plaza
Rt. 30A
Fonda, NY 12068
(518) 853-1247

Glens Falls
84 Broad Street
Glens Falls, NY 12801
(518) 798-6066

Ithaca
10 Arrowwood Drive
Ithaca, NY 14850
(607) 274-4680



Jamestown
The Resource Center
890 East Second Street
Jamestown, NY 14701
(716) 661-1447

Kingston
63 Hurley Avenue
Kingston, NY 12401
(845) 331-8322

Lackawanna
Our Lady of Victory
Family Care Center
227 Ridge Road
Lackawanna, NY 14218
(716) 822-5944

Lockport
Ambulatory Care Center
5875 S. Transit Road
Lockport, NY 14094
(716) 433-2025

Malone
183 Park Street, Suite 3
Malone, NY 12953
(518) 481-2545

Massena
1 Hospital Drive
Massena, NY 13662
(315) 769-4253

Niagara Falls
620 10th Street, Suite 709
Niagara Falls, NY 14301
(716) 285-6663

Olean
Olean General Hospital
623 Main St.
Olean, NY 14760
(716) 375-7555

Oswego
Seneca Hills Health
Services Center
County Route 45A
Oswego, NY 13126
(315) 343-0925

Plattsburgh
43 Durkee Street
Plattsburgh, NY 12901
(518) 561-8310

Rochester
465 Westfall Road
Rochester, NY 14620
(585) 463-2600

Rome
125 Brookley Road,
Bldg. 510
Rome, NY 13441
(315) 334-7100

Schenectady
1475 Balltown Road
Niskayuna, NY 12309
(518) 346-3334

Troy
500 Federal Street
Troy, NY 12180
(518) 274-7707

Watertown
218 Stone Street
Watertown, NY 13601
(315) 788-5050

Wellsville
Jones Memorial Hospital
Health Care Center
15 Loder Street
Wellsville, NY 14895
(585) 596-4111